Social Science & Medicine 96 (2013) 250–257

Contents lists available at SciVerse ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

Institutional design and organizational practice for universal coverage in lesser-developed countries: Challenges facing the Lao PDR

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ARTICLE INFO

Article history:
Available online 4 February 2013

Keywords:
Universal health coverage
Institutional development
Social health protection
Social health insurance
Community health insurance
Lao PDR

ABSTRACT

There is now widespread acceptance of the universal coverage approach, presented in the 2010 World Health Report. There are more and more voices for the benefit of creating a single national risk pool. Now, a body of literature is emerging on institutional design and organizational practice for universal coverage, related to management of the three health-financing functions: collection, pooling and purchasing. While all countries can move towards universal coverage, lower-income countries face particular challenges, including scarce resources and limited capacity. Recently, the Lao PDR has been preparing options for moving to a single national health insurance scheme. The aim is to combine four different social health protection schemes into a national health insurance authority (NHIA) with a single national fund- and risk-pool. This paper investigates the main institutional and organizational challenges related to the creation of the NHIA. The paper uses a qualitative approach, drawing on the World Health Organization's institutional and Organizational Assessment for Improving and Strengthening health financing (OASIS) conceptual framework for data analysis. Data were collected from a review of key health financing policy documents and from 17 semi-structured key informant interviews. Policy makers and advisors are confronting issues related to institutional arrangements, funding sources for the authority and government support for subsidies to the demand-side health financing schemes. Compulsory membership is proposed, but the means for covering the informal sector have not been resolved. While unification of existing schemes may be the basis for creating a single risk pool, challenges related to administrative capacity and cross-subsidies remain. The example of Lao PDR illustrates the need to include consideration of national context, the sequencing of reforms and the time-scale appropriate for achieving universal coverage.

Introduction

While the goal of achieving universal coverage of the entire population is accepted internationally (Chan, 2010; World Health Organization, 2010), exactly how that is to be achieved within lesser-developed countries (LDCs) is much less clear. LDCs present particular challenges, including the difficulties of creating organizational capacity and of covering the large but disparate informal sector. Establishing the most effective health financing settings – revenue collection, pooling of resources and purchasing of services – is essential (Evans & Etienne, 2010; World Health Organization, 2005) but does not provide the whole answer. A more pressing challenge is to build national capacity for managing the complex tasks of providing social health protection (SHP) to the entire population by developing the most effective institutional and organizational structures. This is a key policy issue that remains unanswered by current UC strategies; while a number of LDCs are feeling their way towards UC, largely by trial and error, the evidence base for policy making is weak.

Using tax funding, social insurance and other social protection measures are offered as an effective approach that generates funds, pools risk (Carrin & James, 2005; Evans & Etienne, 2010; World Health Organization, 2000) and protects against the impoverishing effects of unpredictable expenditure (Carrin, 2004; Poleti et al., 2007; Ranson, 2002; Wagstaff, Watanabe, & van Doorslaer, 2001). While a broad

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0277-9536
http://dx.doi.org/10.1016/j.socscimed.2013.01.019

consensus exists on the benefit of creating a single national risk pool (Carrin, 2004; Criel, 1998; Davies & Carrin, 2001; Dror & Jacquier, 1999; Soderlund & Khosa, 1997; World Health Organization, 2000), establishing risk-pooling arrangements in lower-income countries (LICs) is challenging (Ibrahimipour et al., 2011; Poleti et al., 2007; Schieber & Maeda, 1997). There are also concerns that relying on compulsory social health insurance (SHI) mechanisms for the (usually small) formal employed sector will not provide benefits for the poor or informal-sector workers (Gwatkin & Ergo, 2010).

In recent years, health planners in the Lao PDR have considered options for combining four different social health protection (SHP) schemes into a national health insurance authority (NHIA). The aims are to expand population coverage, collect additional revenues outside the government budget, overcome fragmentation and achieve administrative efficiencies. The coverage and protection provided by each of the four existing schemes remain incomplete, resulting in a high level of out-of-pocket payment for health care. Using the case of the Lao PDR, this article investigates the research question: What are the challenges relating to institutional design and organizational practice in creating a national health insurance system in a low-income setting?

A body of literature is emerging on institutional design and organizational practice for universal coverage. Davies and Carrin (2001) acknowledged there was little evidence on the governance and stewardship mechanisms needed to achieve national risk pooling or to measure its impact. Some attempts have been made to gather evidence about the institutional framework for government health service delivery, including health financing, personnel policies and administrative centralization (Oliveira-Cruz, Hanson, & Mills, 2003). Building on a simple framework of key performance indicators related to the three health financing functions within the context of social health insurance provided by Carrin and James (2005), Carrin, Mathauer, Xu, and Evans (2008) proposed to integrate institutional design for universal coverage into a conceptual framework based on the three health financing functions developed by Kutzin (2008). Mathauer and Carrin (2010, 2011) define institutional design as formal rules and legal and regulatory provisions and organizational practice as the way organizational actors implement these rules.

Experience in several African, Asian and Latin American countries illustrates the need for institutional and organizational development for universal coverage. The approach addresses concerns over fragmentation of risk pools in various African countries raised by McIntyre et al. (2008). In Lesotho, for example, a review of options for national social health insurance based its assumptions for financial feasibility projections on adopting an autonomous para-statal agency covering all population groups, including compulsory membership with contributions from the informal sector and exemptions for the poor (Mathauer, Doetinchem, Kirigia, & Carrin, 2007). Similarly, from 2004 Kenya planned a move from a hospital insurance fund with community based health insurance and other demand-side schemes to a single national social health insurance fund (Chuma & Okungu, 2011), although questions of economic feasibility and political acceptability have prevented the adoption of the proposal (Carrin et al., 2007). Following extensive experimentation in health financing arrangements, fragmentation also became a concern in Rwanda, posing the need to strengthen institutional and organizational structures under a reformed national medical insurance agency (Antunes & Saksena, 2009).

In South-east Asia, harmonizing prepayment schemes has been proposed for Lao PDR and Cambodia, where different schemes target the poor, provide voluntary prepayment for the informal sector and cover the small employed sector with compulsory insurance, challenging planners to find the best way to construct institutional arrangements for translating donor and government funding into health-related services (Bloom et al., 2008; Tangcharoensathien et al., 2011). One study in Cambodia concluded that harmonization of the different schemes would require building the capacity of government organizations and investment in institutional development (Antunes, Wanert, Bigdeli, & Ros, 2009). A similar study recommends that Vietnam Social Security (a mixed pension fund and health insurance agency) be reorganized and technical and management capacity strengthened to provide for an independent and professional health insurance system (Tien, Phuong, Mathauer, & Phuong, 2011). Kwon (2011) concludes that coverage of the large informal sector in Asian countries is a major challenge and proposes an optimal mix of tax subsidies and health insurance. One Latin American study argued that in Nicaragua institutional and organizational deficits had caused fragmentation and segmentation of health financing and resulted in excessive out-of-pocket payments (Mathauer, Cavagnero, Vivas, & Carrin, 2010).

Social health protection in the Lao PDR

The Lao PDR is a low-income country where the poor and the informal sector comprise 80% of the total population of 6 million, out-of-pocket (OOP) spending is more than 60% of total health expenditure, and government health spending is constrained (World Bank, 2010a). In 2010, government expenditure was only 33% of total health expenditure and social security expenditure was only 5% of government health expenditure (World Health Organization, 2012).

Currently, four different SHP schemes serve different sections of the population (Thomé & Pholsena, 2009, chap. 3): the State Authority for Social Security (SASS), a compulsory insurance scheme for civil servants (Bouaphat, 2012; Ron & Jacobs, 2009); the Social Security Office (SSO), a compulsory insurance scheme for salaried workers of both state and private enterprises, and, like the SASS, implemented by the Ministry of Labour and Social Welfare (MOLSW) (Bouaphat, 2012; Ron & Jacobs, 2009); Community-Based Health Insurance (CBHI), a voluntary insurance scheme for the self-employed and the informal sector implemented by the Ministry of Health (MOH) (World Bank, 2010b); Health Equity Funds (HEFs), a direct subsidy for families living in poverty to pay service fees and associated costs at government facilities, managed under the MOH by donor-funded non-government agencies (World Bank, 2010b). The characteristics of the schemes are summarised in Table 1. The different SHP schemes are constrained by fragmentation of financing pools and weak implementation arrangements, while population coverage and benefit packages vary widely (Herrera & Roman, 2011). To date the schemes have not had a major impact on reducing OOP spending (World Bank, 2010a).

The combination of the four SHP schemes into a single National Health Insurance Authority (NHIA) has been proposed in a draft Prime Minister's Decree on National Health Insurance (Office of the Prime Minister, 2011). The draft Decree outlines the principles and procedures for national health insurance and the organizational structure of the NHIA. Revenue will be collected in a single national pool through compulsory salary deductions from the formal sector, with a 50% government subsidy for contributions from the informal sector and a 100% government/donor subsidy for the poor, and the NHIA will purchase services from government health providers. The NHIA is proposed as a state organization with department status under the Ministry of Health, with an independent executive board, board of director and administrative bodies. Its purpose is to determine policy for national health insurance, develop and implement a strategic plan and regulations and build government capacity.

Also under consideration is a draft Health Financing Strategy 2011–2015 (Ministry of Health, 2010). The wide-ranging strategy includes proposals for increased public-health spending from domestic sources and recommends developing a plan to merge the

Table 1
Summary of social health protection schemes in the Lao PDR.

	SASS	SSO	CBHI	HEFs	All schemes
Ministerial authority	MOLSW	MOLSW	MOH	MOH	MOLSW, MOH
Year est.	2006 (revised scheme)	2001	2002	2004	
Legal tool	PM decree	PM decree	MOH regulation (national regulation)	MOH regulations are project based	
Target population	Civil servants and dependents, retirees, military personnel	Employees of enterprises and dependents	Informal sector, non-poor, self-employed and dependents	Households identified as poor by each HEF	Total population
Geographical coverage	National (17 provinces covered)	7 provinces are covered	Currently in 26 districts of 10 provinces with the expansions planned	Currently in 98 districts with expansions planned	
Contribution	Gov't and employee salary deductions	Employer and employee salary deductions	Household premium payment	Donor and gov't subsidies	
Purchasing of services	Principally capitation payment to gov't service providers	Principally capitation payment to gov't service providers	Principally capitation payment to gov't service providers	Typically fee-for-service reimbursement to gov't service providers	
Estimated number of persons in the target population	450,000 persons (excluding about 590,000 military and police and their dependents)	386,988 persons	3 million persons	1.6 million persons	6 million
Coverage as of 2012	355,272	124,583	140,000	713,944	1,333,799
% of targeted population	79	32	5	45	22

Abbreviations: SASS, State Authority for Social Security; SSO, Social Security Office; CBHI, Community Based Health Insurance; HEF, Health Equity Fund; MOLSW, Ministry of Labour and Social Welfare; MOH, Ministry of Health; PM, Prime Minister. Source: Bouaphat Phonvisay, Ministry of Health, Lao PDR, July 2012.

existing SHP schemes. The Strategy sees the organizational framework for a merged scheme and the ability to attract a skilled workforce as unresolved issues. The Strategy calls for new measures that replace the practice of basing health facility user-fee revenues on pharmaceutical purchases through revolving drug funds (RDF), which has caused strong incentives to government providers both to over-prescribe medications and to withdraw from CBHI schemes that impose capitation payment ceilings. Prepared for and on behalf of the MOH, two further 'roadmap' documents recommend the parallel development of compulsory and voluntary membership schemes at the same sites, administered through the proposed NHIA (Herrera & Roman, 2011; Ron & Jacobs, 2009). A first step could be the amalgamation of the SASS and SSO schemes within the MOLSW.

Methods

This paper uses data collected for a study of policy challenges and organizational barriers associated with the creation of the NHIA in the Lao PDR. In an analysis of the key policy documents, we reviewed the draft Health Financing Strategy 2011–2015 (Ministry of Health, 2010) and the draft Decree on National Health Insurance (Office of the Prime Minister, 2011) along with key documents provided by government, national and donor–partner agencies (Ministry of Health, 2011; World Bank, 2010a, 2010b, 2010c).

We interviewed 17 key informants working nationally at the policy and operational level, purposively selected as those health financing policy makers who are known to have played an active role in the formulation of policy and practice for SHP in Lao PDR and who were available for interview. Table 2 summarises the characteristics of these stakeholders from the ministries of health, finance, and labour and social welfare and development partners. We believe that the key informants are representative of the range of views that are prevalent within government and among development partners. Based on a semi-structured questionnaire, these key informants provided their views about the creation of the NHIA. The interviews were conducted in English and noted by hand by the first author in September 2011. Consent for the interview was provided by all informants and participant comments were de-identified. Ethical approval was not required to conduct policy related 17 key informant interviews in the Lao PDR.

The conflicting views of key informants were reported and no attempt was made to resolve these differences (Brenzel & Naimoli, 2009). Our aim was to represent the variety of views faithfully, reflecting an ongoing discussion among stakeholders with no clear 'sides' or counter-positions. Potentially, organizational attachments may have an influence on the results: those assigned to manage the CBHI system, for example, may have a stronger interest in describing its implementation as a success; officials at the SASS and the SSO may have a vested interest in maintaining an independent structure. However, we do not believe that these possible biases affect the reporting of the results or the interpretation we bring to them.

Analysis of the data from the documentary review and key informant interviews was guided by the World Health Organization's institutional and Organizational Assessment for Improving and Strengthening health financing (OASIS) conceptual framework proposed by Mathauer and Carrin (2011) (Fig. 1). The OASIS framework is based on an understanding that health financing performance depends on the institutional design and organizational practice of the health financing system. The framework first analyses the stewardship functions of the MOH with respect to the three health financing functions: resource collection, pooling and purchasing of services. For each category, the framework proposes an analysis of institutional design and organizational practice that in turn affect nine key health financing performance indicators (listed in Table 3 below). While the OASIS approach has so far been used mostly as a means for country situation analysis, we argue that – if issues related to context, sequencing and timescale are added – the framework may also be used as an effective tool for planning

Table 2
Characteristics of the key informants.

Sex	Male	14
	Female	3
Organizational focus	Ministries	11
	Development partners	5
	National Institute for Public Health	1
Program implementation role on social health protection schemes?	Yes	7
	No	10

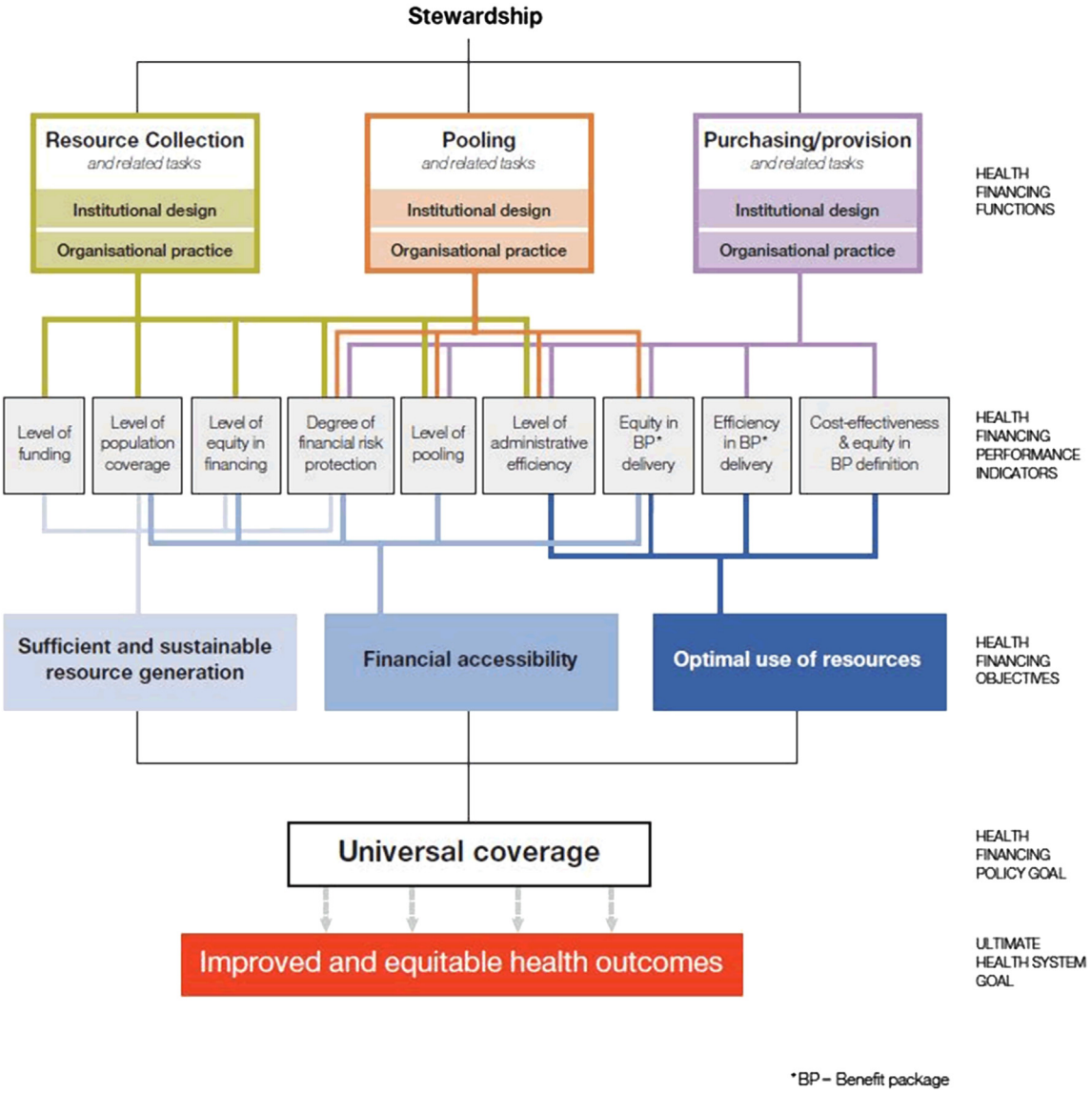

Fig. 1. The OASIS framework. Source: Mathauer and Carrin (2011)

and policy development. By context we refer to the administrative and human resources capacity for implementation of UC. Sequencing refers to the order in which the major reforms are implemented, and their content. Timescale refers to the likely period of time, usually decades, required to achieve full UC.

Findings

Reponses from key informants were analysed under three themes related to the creation of the NHIA: institutional design for health financing, organizational challenges and the potential impact of the NHIA on health financing performance. The findings reported in this section exclusively reflect the views of the key informants.

Institutional design for health financing

Stewardship and accountability

Key informants argued strong political leadership will be needed to bring change in policy, administration and implementation. While key informants favoured the establishment of an autonomous authority, no clear agreement emerged on the location of the NHIA: the Office of the Prime Minister (PM), the MOH and the MOLSW were all suggested. The PM's Office was favoured as the means to provide political leadership, strengthen coordination, reduce tensions between ministries, and enforce monitoring. Key informants from development partner agencies mostly rejected locating the NHIA at the MOH (responsible for CBHI and HEFs) and favoured the MOLSW (which administers the SASS and the SSO and has greater human resource capacity), noting, however, that the MOLSW may not have an interest in coverage of the informal sector.

Resource mobilization

Key informants recognised that guaranteeing sufficient funding for the NHIA, including reliable and equitable collection of member contributions, would be a major challenge. They reported proposed government contributions were limited, compliance with SASS and SSO procedures was currently incomplete, CBHI premium collection was low, and continued donor funding for HEF schemes was not guaranteed. Most understood that funding increased coverage of the informal sector is a particular challenge, as expanding

Table 3
Potential impact of the NHIA on the health financing performance indicators.

#	Indicators	Possible impact	Barriers
1	Level of funding	Additional funding for subsidies will increase General Government Expenditure on Health. Higher collection of premium contributions through enrolling new members from the informal sector.	No clear commitment from government and donors. Low compliance in compulsory collections; difficulty implementing a system of compulsory collection of contributions from the informal sector.
2	Level of population coverage	Compulsory membership of the NHIA with subsidies for the informal sector and the poor would lead to higher population coverage.	Inclusion of the informal sector under compulsory membership may not be possible. Inability to subsidize informal sector contributions and the poor.
3	Level of equity in financing	Increased population coverage and subsidies for the informal sector and the poor will increase equity in financing and access to health services.	Agreement on cross-subsidization from the formal sector is not certain. Development of a system to identify beneficiaries for a subsidy is not yet evident.
4	Degree of financial risk protection	Smaller percentage of households experiencing catastrophic expenditure.	Population coverage is limited and willingness to pay insurance premiums is constrained.
5	Level of pooling	Risk pooling will be maximised through compulsory membership and merging of the pools through NHIA.	Agreement on having a single risk pool for all the schemes is not guaranteed.
6	Level of administrative efficiency	Reduction of administrative cost through adoption of a common financial management, accounting and information system.	Coordination between participating agencies and ministries will require high level political intervention.
7 8	Equity in benefit package delivery; and, Efficiency in benefit package delivery	A common, equitable and efficient, benefit package (based on budget constraints and society's preferences) implemented at different levels of service.	Policy decisions required for a uniform benefit package to ensure equity at the different levels (primary, secondary and tertiary) may not be agreed to. Reliance on Revolving Drug Fund policy is inefficient.
9	Cost effectiveness and equity in benefit package definition	A common benefit package delivered under the NHIA to the whole population at the least cost.	Resources will not be available to fund a uniform, inclusive and equitable package.

Source: Conceptual framework as outlined in the left column based on Mathauer and Carrin (2011).

voluntary insurance membership is difficult and the drop-out rate is significant. More broadly, key informants agreed that agreement for sufficient financial commitment for demand-side subsidies across government, including the Ministry of Finance, was not certain.

Enrolment and collection mechanisms

Options suggested by key informants for extending coverage included mandatory membership for the informal sector, allocating direct subsidies to CBHI or contributions collected indirectly alongside the land tax or through village chiefs, though no agreed solution to this problem was reported, and tax collection systems at the village level in general were weak. While the draft Decree proposes compulsory CBHI membership, there was concern that raising CBHI coverage in this way presupposed a major increase in the quality of care at contracted government facilities, requiring in turn a major increase in the government health budget.

Fund and risk pooling mechanisms

It was argued that creating a common risk pool among the four schemes would make financing more sustainable and provide for cross-subsidization from the SASS and SSO schemes to the informal sector. Some key informants proposed that direct subsidies (from government or donors) for the poor and the informal sector be included in the risk pool, though they understood that this could lead to leakage in the use of funds targeted on the poor. Others recognised that reliable information on the size of the population requiring subsidies was not available, no comprehensive beneficiary identification system existed, and no monitoring system for verification and control was in place for the subsidy programs. As well, key informants suggested that the MOLSW may not be willing to underwrite the creation of a single risk pool with cross-subsidization. One suggestion was not immediately to unify the four schemes financially but to begin with the merger of the SASS and the SSO and later bring in the CBHI and HEF schemes.

Design of the benefit package

Benefit packages for the different schemes are detailed in government guidelines, though in practice, according to key informants, each facility delivered services according to the equipment available. The benefit package, they argued, must be affordable nationally and meet provider revenue needs at the facility level; to maintain equity, benefits need to be equal for equal need, and contributions based on ability to pay. Key informants thought moving to uniform coverage under a single national agency would require a common benefit package that is transferable between schemes and regions. Key informants believed the management authorities of existing schemes may not support a unified benefit package if it added to costs, particularly as delivering a uniform quality of care rests on the availability of adequate equipment and supplies.

Payment mechanisms

Key informants argued that inefficiencies in funding service provision may be reduced through implementation of a consistent and well designed provider payment mechanism. While different provider payment mechanisms, such as capitation, fee-for-service and case payment were proposed, key informants generally preferred using capitation payment at the primary level and case payment or fee-for-service at the secondary and tertiary level.

Organizational challenges

Organization and staffing

Key informants reported that organizational structures and reporting arrangements of the proposed NHIA had not been resolved and would be affected by its location – whether at the PM's Office, MOLSW or MOH. A key concern was to account for existing CBHI–HEF structures within the MOH alongside the more well developed SASS and SSO structures within the MOLSW. The incomplete use of existing health insurance information and

technical capacity located within the MOLSW may be overcome, they argued, by closer coordination between the different ministries. Key informants felt that attracting scarce operational and technical staff to the new authority from the existing agencies (including health-systems, health-financing, public-health management, information-technology, actuarial and financial management specialists) could face resistance if existing departments could not spare experienced professionals; and skilled staff may be reluctant to move if there were uncertainties about the sustainability of an NHIA. Raising government employment quotas, capacity development activities, recruiting Lao PDR staff with international experience and recruiting professionals from the private sector were all proposed options.

Information management system

Key informants emphasised the need for stronger information systems to provide data on providers and members, membership contributions and hospital statistics at the central level for decision making on management, financing and quality improvement. Many argued the task of unifying existing data systems for the different SHP schemes that were developed separately would be difficult, especially in a context where vital registration is non-existent. They also understood creating a central database is essential to linking the existing SHP schemes and would require technical support for building the infrastructure for information technology.

Financial management system

Procedures for independent banking arrangements, decentralized funding, a capable financing team and guidelines for the timely release and use of funds had not been addressed in the draft Decree or official documents. Agreement about the decentralisation of administration and fund disbursement was tempered by different opinions about implementation arrangements across the different schemes: the SASS and SSO already had centralised arrangements, with provincial offices, while CBHI schemes were simply district-based. To harmonize implementation arrangements among existing schemes, some key informants recommended the establishment of NHIA branch offices at the provincial level while others recommended using the existing infrastructure of one of the ministries. While some suggested NHIA funds could to be channelled from the central level to the district level through the provincial governments, they reported there were no regulations currently to guarantee the timely release of the funds to the insurer or the health provider. One of the main difficulties, informants said, was the lack of financial management capacity due to shortage of funding and qualified human resources.

Administration and monitoring

It was anticipated that the unification of management, accounting and statistical reporting, a common computer system and centralised monitoring under the NHIA would reduce administrative costs currently borne by the MOH, MOLSW and other ministries. Key informants believed high-level political intervention could help reduce transaction costs caused by efficiencies in coordination between the participating ministries and agencies. They proposed that management and monitoring could be arranged efficiently at national, provincial and district levels with internal and external auditing through existing procedures. Improving capacity, particularly for monitoring and compliance, would be required.

Potential impact on health financing performance

Based on key informant responses, Table 3 summarises the possible impact of, and barriers to, changes in institutional design and organizational practice under the NHIA on heath financing performance, following the nine performance indicators outlined in the OASIS framework. Table 4 summarises the main bottlenecks to institutional design and organizational change identified by Mathauer and Carrin (2011). Briefly, key informants reflected on the possibility that establishing an NHIA could lead to increased government commitment, more complete compliance could raise funding for health care, direct subsidies and agreement to cross subsidies that favour the informal sector could increase equity and financial protection, appropriate political intervention could help create a single risk pool and achieve administrative efficiencies, and replacing the revolving drug fund policy could assist implementation of a uniform benefit package and an effective provider payment mechanism.

Discussion

Lesser-developed countries face particular challenges of institutional design and organizational practice in moving towards UC. These challenges reflect a situation of high levels of poverty, a large informal sector, limited resources and limited capacity for planning and administration. Addressing these barriers requires attention to particular elements of context, of the sequencing of reforms and of the timescale needed for implementation.

The capacity for political leadership and government capacity for planning and implementation are key contextual constraints.

Table 4
Existing situation of six barriers in institutional design and organizational practice.

	Barriers	Existing situation
1	Rule absence	Approval of the Decree on Health Insurance is in the final stage of consideration. No regulations have been drafted to guide the implementation of the decree.
2	Inadequate rule	Questions related to compliance in the formal sector, mandatory membership in the informal sector, subsidized membership for the poor, cost-sharing that is affordable and equitable, effective risk-pooling and positive cross-subsidisation are unresolved.
3	Contradictory rule	The proposed location of the NHIA is uncertain. Within the MOH, issues related to the roles of service provider and purchaser threaten a conflict of interest. Continued reliance on revolving drug funds for provider payment prevents effective purchasing. Without a single fund pool, cross-subsidization between formal and informal sectors cannot be guaranteed.
4	Weak rule enforcement	Compliance with the compulsory formal sector schemes is poor. Uncertain who will the provide leadership, political support and incentives needed to merge the schemes and create the new Authority.
5	Weak organizational capacity	Organizational and human resources capacity for implementing the NHIA are limited, especially at the MOH. Capacity building will require more time.
6	Dysfunctional inter-organizational relationships	Divergence between the MOH and MOLSW (and the PM Office) restricts progress. There is a lack of clarity on decision making structures and mechanisms for coordination between ministries and departments. The correct incentives for change are not in place.

Source: Conceptual framework as outlined in the left column based on Mathauer and Carrin (2011).

LDC governments who propose to levy the population through national health insurance as a means to compensate for limited government financing may face severe constraints in the collection of revenues. The WHO Health Financing Strategy for the Asia Pacific Region (2010–2015) argues that universal coverage is difficult to achieve if general government health expenditure is less than 5% of GDP (World Health Organization, 2009). In Lao PDR, general government health spending is less than 1% of GDP (Thomé & Pholsena, 2009, chap. 3). Though a middle-income country, the example of Mexico indicates the level of commitment and resources required for achieving UC as a single national program: To implement the reform, the government *increased* public funding for health by 1% of gross domestic product over seven years from 2003 (Frenk, Gómez-Dantés, & Knaul, 2009). In LDCs too, governments face a political choice in defining their national health insurance proposals either as a non-tax revenue raising exercise or as a program that provides effective social health protection. Clearly, a balance is needed between the two.

In Lao PDR, while the draft NHI Decree establishes the government's policy commitment to achieving universal coverage, there is little consensus among policy makers and key stakeholders on the proposed arrangements. The government pledges to provide a tax exemption for the NHIA, guarantee the supply of staff and funding for management, and extend the national health insurance scheme nationally, and it looks to all economic sectors, both domestic and foreign investors, to contribute to the development of NHI. However, the revenue raising proposals of the draft Decree indicate that the government sees the proposal for NHI mainly as an opportunity for cost-sharing among households and revenue-raising outside the national budget. While expanding the revenue base for national health insurance is a legitimate aim of the reform, policy makers have not made clear whether additional revenues can be collected without adding to household co-payments and OOP expenditures.

Countries must define their own path to UC within parameters that are consistent with overall health financing goals (Kutzin, 2012; World Health Organization, 2010), though outcomes will depend on the national priority given to the health sector (Kutzin, 2008). This implies that the sequence given to the implementation of reforms will be decisive. LDC governments are unlikely to have the resources or the capacity to implement UC as a single national reform. The example of Thailand, now a middle-income country, shows that sequencing reforms is effective and necessary. While Thailand boasts a universal coverage system, it has not yet formed a single risk pool across its three main universal coverage schemes for civil servants, formally employed workers and the informal sector (Tangcharoensathien et al., 2011).

Unifying risk pools for different sections of the population may not be practicable initially. Guaranteeing coverage of the poor is a logical first step (Gwatkin & Ergo, 2010). As well, in countries like Lao PDR, coverage of the expansive informal sector remains an unresolved challenge. In Vietnam, while the government has unified its Health Care Fund for the Poor with formal-sector social health insurance through Vietnam Social Security, coverage of the informal sector remains incomplete (Tien et al., 2011). Thailand provides an example of effective coverage of the informal sector with tax-based funding (Tangcharoensathien et al., 2011). The proposal for mandatory coverage of the informal sector in Laos PDR (supported by a government subsidy for 50% of premium rates) is a response to the failure of voluntary coverage schemes there. However, it is precisely the disparate nature of such a population group that prevents mandatory enrolment.

Reforms must therefore occur in a logical order depending on the status of health financing arrangements within the country. Establishing the institutional and organizational structures needed for UC may provide the means for countries to devise the health financing policy settings needed to expand coverage. This may be thought of as a process of learning by doing. In such a process, the understanding that such reforms require an extended period is critical. In Kenya, for example, proposals for a national health insurance agency appeared in 2004. Differences among stakeholders and concerns within parliament, however, prevented implementation of the plan. Reviewing the situation, Carrin et al. (2007) recommended a well-prepared transition period of perhaps a decade based on establishing a national health insurance fund and then meeting the challenges of implementation.

In Lao PDR, it appears the NHIA has been conceived as a planning and preparatory body rather than an implementing agency. While it has been defined as an organization designed to implement the health insurance policy, 'implementation' in this context has more the sense of managing the movement towards establishment of a national authority than organizing a national insurance agency. Evidence for policy making may be derived from international experience. It may also come from piloting and evaluation within the country. The evidence from Lao PDR shows the need for greater attention to institutional rules, organizational structures, strengthening capacity for policy development and decision making, improved mobilization of resources and stronger administrative capacity across government. These challenges are not unique to Lao PDR but are evident in other lower-income countries, in which a well-prepared transition period, based on establishing a national health insurance fund and then meeting the challenges of implementation, may be required.

Conclusion

This article aims to fill a gap. While the principles of universal coverage are widely accepted, the means for moving towards UC goals in LDCs is poorly documented and the evidence base is limited. Lao PDR provides one example of a lower-income country in which there is a small formal sector, a large informal sector, and significant poverty. This situation constrains fiscal resources, limits revenue collection opportunities and reduces the potential for positive cross-subsidization. Reflecting a global concern, the Lao PDR example confirms that voluntary insurance is inappropriate for coverage of the large informal sector. Despite the hopes of some Lao PDR policy makers, mandatory membership of insurance schemes may be prevented by the disparate nature of the informal sector, and a mix of tax subsidies and health insurance is required. Cross subsidization from formal-sector schemes may appear attractive but raises a number of technical and financial concerns. In lower-income countries, the means for moving towards universal coverage may be seen therefore as a process of capacity development.

Having adopted the strategy of universal coverage, many countries now face the challenges of implementation as a national reform in the health financing system. In LDCs, the most immediate steps along this path include extensive change and reform to the institutional design and organizational practice elements of the three health financing functions. Dealing with these challenges demands that three concepts be strengthened in the analytical framework. In considering the national context more attention is needed to the process by which national capacity for planning and implementation may be strengthened, rather than simply accounting for the shortcomings. The nature and sequencing of reforms, including interventions required to prepare the establishment of a single national risk pool, need fuller consideration in order that preliminary changes may pave the way for effective implementation of broader reforms. And the timescale required for introducing universal coverage, which will be longer-term rather than immediate, needs to be carefully measured. Universal coverage is possible; the challenge now is how to achieve it.

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